AMA Submission to the

Senate Community Affairs Committee

Inquiry into Compliance Audits on Medicare Benefits

April 2009

Introduction

The fundamental concerns of the AMA in relation to the government's proposal to increase the audit powers of Medicare Australia is that it compromises the central ethic in medical practice which preserves the privacy of the doctor-patient relationship. The integrity of the confidentiality of the patient medical record is absolutely essential to developing, enhancing, and underpinning the therapeutic relationship. This confidentiality secures the necessary trust and openness that characterises the ongoing communication between doctors and their patients to optimise patient care.

The exposure draft of the *Health Insurance Amendment (Compliance) Bill 2009* (the Bill), released on 9 April 2009, is created for the purposes of Medicare Australia compliance duties. The Bill aims to extract information, including personal health information, from patients' medical records in order to satisfy compliance objectives. It gives powers to Medicare Australia that will compel doctors to provide information from a patient medical record where the administrative audit by Medicare Australia will have no other source of information to satisfy the administrative compliance requirements.

This places doctors in immediate conflict with the ethos of medical practice that requires them to safeguard the personal information of their patients. It immediately destroys patients' security in the confidentiality of their medical history and puts up barriers to patients' comfort in providing private and personal information to their doctor in order to receive the most appropriate and best care for their needs.

Rather than a mere administrative issue, this measure, as set out in the exposure draft of the Bill, fundamentally undermines the widely accepted community understanding that a patient's private health and personal information remains confidential to their treating doctor. It is understood that the information may be required to assist the courts in resolving matters that are clearly grave issues such as criminal activity. But the access to these records for the purpose of Medicare audit falls well below the threshold for the need to breech patient privacy with the powers available in the Bill.

Similarly, it is not sufficiently valid for the government to argue that this legislation will provide doctors with convenient legislative cover for the transfer of personal health information to Medicare Australia. The cost that this legislation incurs in undermining the trust that patients have in their doctors to maintain the confidentiality of their medical record will result in a fundamental alteration of the community's confidence in the security of their private and personal information and is too high a price to pay. This unnecessary entrance by government into patients' medical records cannot be justified when other processes exist to deal with the low level concerns Medicare Australia has with the use of the MBS, and to address the small number of high level concerns.

The AMA contends that current medical practice relies on the patient medical record to be a reasonable reflection of the medical care provided to the patient, and therefore

it holds a variety of private and personal information with regard to many perspectives of the patient. It is not primarily a record of the Medicare items associated with that patient's care and it is essentially an unsuitable document to be used for an administrative check of the ascription of those items by Medicare Australia. The patient medical record was not intended to be the source to meet Medicare Australia's compliance obligations, rather it is the record keeping tool which assists the doctor meet the ongoing medical care needs of the patient.

The AMA is very concerned that the government is conflating two very distinct activities. Whereas doctors record the ongoing care of a patient in a separate and confidential medical record, they do not necessarily prepare that record primarily to satisfy an administrative requirement from Medicare Australia to substantiate the ascription of a particular Medicare item to any particular service.

As the peak professional organisation representing medical practitioners in Australia, the AMA is a strong supporter of the Medicare benefits arrangements. Through the payment of Medicare rebates, the Government assists patients with the cost of private medical care. Consequently, all eligible Australian residents have the support to access high quality, affordable medical services.

The medical profession assists patients in accessing their government rebate by including Medicare Benefits Schedule (MBS) item numbers on accounts for medical services. This allows Medicare Australia to process 278 million patient rebates each year quickly and with very little administrative cost to the taxpayer. Indeed, Medicare claiming, including the process whereby doctors itemise accounts with Medicare item numbers, is about ensuring that patients receive a government rebate. It is not about doctors' incomes. Nevertheless, this service provided by doctors for patients on behalf of government is often described as doctors billing Medicare for their services.

The Bill places the onus on doctors to provide personal health information to Medicare Australia under the inaccurate assumption that billing of the Medicare items are a supplement to the income of doctors when they are in reality a subsidy for the patient's cost.

The AMA is a strong supporter of appropriate audit activity to ensure the integrity of the Medicare arrangements. We do not condone doctors ascribing items for services they have not provided or patients claiming a Medicare rebate for services that they have not received.

Medicare Australia is able to detect and take action against doctors deliberately doing the wrong thing with the suite of powers it currently has. These powers allow reasonable compliance checks to be made by Medicare Australia, with the co-operation of the doctor, when Medicare Australia identifies a doctor whose billing pattern shows up as a statistical outlier. The current powers also allow for patient medical records to be subpoenaed as evidence when a genuine case of serious misuse of the system has been identified. Under these current powers, Medicare Australia has previously identified and successfully prosecuted a number of doctors who have acted inappropriately in terms of Medicare rules and requirements.

We accept that patient medical records may need to be accessed when an issue has been investigated and determined to be of such gravity that it is being dealt with as a potential criminal matter in court. But it is very difficult to accept the same diminution of privacy of patient medical records when an issue is only at the point of initial administrative checking to determine whether the ascription of an MBS item number on a bill or receipt was accurate.

The government claims that it must increase the compliance audit program, because the number of MBS items and the number of providers has grown. It intends to do so by:

1. increasing the number of audits conducted (at a cost of $76.9m);
2. accessing medical records to administratively verify Medicare billing; and
3. introducing additional financial penalties for incorrect billing.

The fact that the MBS program has expanded is a direct result of government policies to cover more services under the MBS and to extend the MBS to different types of healthcare providers. Expenditure on the MBS has increased because of these two factors, as well as an increase in demand for health care from a population that is ageing and has a high incidence of chronic disease. There is no evidence to support the proposition that these factors correlate to increased non-compliance.

While the AMA and the medical profession understand the government's desire to contain ever increasing health care costs, the Increased MBS Compliance Audits Initiative should be an evidence-based proposal to address known problems. The medical profession has already felt the effects of the increased number of audits this year. In particular, Medicare Australia has targeted the use of practice nurse items, at the same time the Minister for Health and Ageing is encouraging doctors to make better use of their practice nurses so that more health services are available to the community. In this context, the initiative works against the thrust of responding to the increased needs of the people, and instead appears as cost containment.

The exposure draft of the Bill would require doctors, at the request of Medicare Australia, to produce documents that are "relevant to ascertaining whether the amount paid in respect of the professional service should have been paid" (lines 31 and 32). There is no requirement for doctors to keep separate administrative records for Medicare Australia's audit purposes and the Bill does not create such a requirement. Nor does this proposal, as set out in the exposure draft of the Bill, provide any detail about exactly what information will be required by Medicare Australia in undertaking their audits. The exposure draft of the Bill puts the onus on the doctor to decide what information he or she will have to provide in order to satisfy the questions of the audit. In fact in the majority of cases the information about what occurred during a patient consultation, and why any MBS rebate was generated, will **only** be recorded in the patient medical record as part of personal health information kept by the doctor to assist them in their ongoing treatment of the patient.

This means that the doctor is expected and obliged to breech his ethical and professional commitment to maintain patient confidentiality, and Medicare Australia will have the power to view, copy and keep extracts from the patient medical record.

The vast majority of doctors are honest and ethical in their billing of MBS items. There is no justification for Medicare Australia to be given more invasive, wide reaching unilateral powers to access personal health information contained in patients' medical records to undertake administrative verification (or compliance audits) of Medicare billing.

While medical records that doctors create and retain for their patients do contain technical medical details such as the results of blood tests, details of referrals to other doctors, height, weight and other technical information about the patient's health status, in many instances they also contain relevant personal information that the patient divulges to the doctor during the consultation such as their feelings, their mental state, relationship issues (which often involve identifying individuals other than themselves), details of their behaviour and information about actions or events which may have an impact on their health and which they are prepared to share only with their doctor. This information can be critical to the treatment plan. If it is withheld, it can compromise the wellbeing of the patient and the doctor's ability to provide the best and most appropriate care.

The relationship between a doctor and their patient is fundamentally based on confidentiality and trust. Patients share their most intimate details with the doctor. The confidentiality between a doctor and his or her patient is critical to the quality of care the doctor provides. The doctor is confident that he or she has all the information needed to make a diagnosis and to provide care and treatment. The patient trusts his or her doctor to keep their confidence and to provide quality care.

The AMA is very concerned that, as a result of these legislative changes, patients will withhold information from their doctor if their private and personal health information could be provided to third parties other than for medical care.

In summary, compliance issues should not take precedence over unfettered access to personal information. Public probity concerns to protect government expenditure are important, but in a scale of importance, they rank lower than the protection of personal health information that risks undermining the ongoing health care of individuals.

Consequently, a compliance system needs to be devised whereby the necessary and limited technical information that satisfies the ascription of the MBS item numbers can be captured without compromising good health care. What the government's measure does, as reflected in the exposure draft of the Bill, is override the privacy protections of the patient in the interests of broad ranging compliance procedures that are currently ill-defined and haphazard in structure and execution.

Background

It is important to understand how the private medical profession finds itself accountable to a government program that provides financial assistance to the public. The MBS arrangements centre on the payment of benefits to patients to assist them

with the cost of their medical care. To facilitate the payment of benefits to patients by Medicare Australia, almost all medical practitioners include MBS item numbers for services rendered on their accounts. This allows Medicare Australia to process the payment of benefits quickly with minimal up-front verification so that individuals can receive their rebates quickly[1].

Doctors are actually under no obligation to include MBS item numbers on their accounts. Doctors could choose to use words to "describe the professional service" sufficient for government officials to identify the actual MBS item number that relates to the professional service[2]. It is an important administrative convenience for patients and government that doctors enable processing of MBS claims by interpreting item descriptors and then including the relevant MBS item numbers on their account. It also provides significant administrative cost savings to Government and the taxpayer.

The doctor selects the MBS item which appropriately reflects the service that has been provided to the patient. In selecting an MBS item number for the purposes of a patient rebate, doctors put themselves at risk of being judged by administrative staff of Medicare Australia to have "incorrectly billed" an MBS item. In order to verify that the appropriate item number has been chosen, a trained administrative officer would have to obtain access to and read the patient's clinical notes. These administrative auditors would not have the insight of a doctor in understanding the requirements of a consultation in order to make that judgement (unlike the Professional Services Review function described later in this submission).

The government itself acknowledges "The number and range of items, as well as the complexity of both Medicare and the Pharmaceutical Benefits Scheme may result in misinterpretation or misuse of the schedules"[3]. The complexity of the MBS can lead to a difference of opinion between providers and Medicare Australia staff in the clinical interpretation of an item descriptor and the requirements for the payment of rebates under the item.

AMA concerns with the measure

The AMA concerns with the measure are based on the information provided by government in *Budget Paper No. 2 2008-09* (page 404), the *Increased MBS Compliance Audits Information Sheet* (October 2008), *The Increased MBS Compliance Audit Initiative Information Sheet 2 – Your questions answered* (February 2009), the exposure draft of the *Health Insurance Amendment (Compliance) Bill 2009* and explanatory memorandum released on 9 April 2009.

[1] Increased MBS Compliance Audits Information Sheet 16 October 2008.
[2] Subregulations 13(2), (2A) and (3) Health Insurance Regulations 1975.
[3] Medicare Australia National Compliance Program 08-09. Page 5.

Access to medical records

It is clear that the purpose of the measure is to increase the audit powers available to Medicare Australia to "gain access to medical records" supporting Medicare billing[4]. This is confirmed by the inclusion of subclause 2(7) in Schedule 1 of the Bill.

The AMA opposes the introduction of a requirement for doctors to provide Medicare Australia staff with information from confidential patient medical records.

Current legislation regarding medical records in respect of Medicare matters
Where existing legislation requires doctors to provide information containing clinical details relating to a patient in respect of Medicare matters (as set out below), government officials who are not medically trained are precluded from accessing, reviewing and making decisions on that information.

This is not the first time Parliament has been asked to give Medicare Australia the power to access information containing clinical details relating to patients.

Medicare Australia investigations of offences and civil contraventions
In 1993 the government introduced the Health Legislation (Powers of Investigation) Amendment Bill 1993 (the Investigation Bill) to provide the (then) Health Insurance Commission (the HIC) with powers to access medical records during investigations. The Investigation Bill also included measures to strengthen the capacity of the HIC to investigate and pursue fraudulent claims under Medicare and to introduce the Professional Services Review scheme (the PSR).

During debate on the Investigation Bill, following significant community concerns and a Senate inquiry into the appropriateness of a power to allow HIC officials to look at clinical information, government accepted the importance of protecting the privacy of medical records. It moved government amendments that not only removed the relevant clauses from the Investigation Bill, but put beyond doubt that the (now) Chief Executive Officer of Medicare Australia does not have the power to require the production of information containing clinical details relating to a patient when conducting investigations.

Consequently, subsection 8P(3) of the MA Act expressly provides that the power to require information to be given or documents to be produced during an investigation does <u>not</u> include:

a) the power to require information to be given about the contents of a part of a record that is a part containing clinical details relating to a patient; or
b) the power to require production of a part of a record that contains such clinical details.

[4] Budget Paper No. 2 2008-09 page 404.

This power is now being sought by Medicare Australia to undertake administrative checks, i.e. much earlier in the compliance program process. The same principles and concerns apply today as they did in 1993.

Professional Services Review
The object of the Professional Services Review Scheme (the PSR) is to protect the integrity of the Medicare benefits and pharmaceutical benefits arrangements. The AMA is a strong supporter of the PSR scheme, which provides an effective peer review mechanism to deal fairly with concerns about possible inappropriate practice. The Director of the PSR is a medical practitioner appointed by the Minister Health and Ageing with input from the profession.

The PSR reviews and investigates the provision of services by a person who may have engaged in inappropriate practice. Inappropriate practice, as defined in section 82 of the *Health Insurance Act 1973* (the HI Act), is essentially where the conduct of a practitioner in rendering or initiating services is unacceptable to the general body of their professional peers.

Reviews and investigations by the PSR are undertaken by doctors who understand and can interpret clinical information and are under a professional oath to deal with that information appropriately.

The *2007-08 Professional Services Review Report to the Professions* provides a succinct description of the PSR process. An extract of the relevant part of that report is at Attachment A.

Sections 89B and 105A of the HI Act provide the Director of the PSR and PSR Committees, respectively, with the power to require the production of documents or the giving of information, including clinical or practice records. These records are reviewed by the Director and/or PSR Committees, which comprise medical practitioners, for the purpose of determining whether inappropriate practice has occurred.

Information about pathology and diagnostic imaging services
Section 23DKA of the HI Act provides the CEO of Medicare Australia with the power to request an approved pathology authority to provide a record of a pathology service to an employee of Medicare Australia.

However under subsection 23DKA(7) an approved pathology authority is <u>not</u> required to produce a record containing clinical details relating to a patient to an employee of Medicare Australia unless he or she is also a medical practitioner. Subsection 23DKA(5) goes even further – an employee of Medicare Australia who is not a medical practitioner cannot even make and retain copies of, or take and retain extracts from, any record produced by an approved pathology authority that contains clinical details relating to a patient.

Access to clinical details relating to a patient is further limited by regulation 16A of the *Health Insurance Regulations 1975* that requires an approved pathology authority to keep a record of the pathology service that contains a copy of a report of the

service, the name of the person to whom the service was rendered and the date on which the service was rendered.

Section 23DS of the HI Act provides identical provisions in respect of records of diagnostic imaging services.

Comment
Currently, when Medicare Australia officials are investigating offences and civil contraventions they cannot require medical practitioners to provide information or documents that contain clinical details relating to patients. The AMA notes that government is not proposing to change this as there are no provisions in the Bill to amend section 8P of the MA Act. This is because they are seeking to gain this power to obtain this information much earlier in the compliance process. This will mean that Medicare Australia will already have the information in their possession by the time they are investigating a relevant offence or relevant civil contravention, which occurs later in the compliance process.

In summary, in the very few specific cases where there is a power in existing legislation for medical practitioners to produce information, documents or records that contain clinical details relating to a patient, only medical practitioners access and review them except by subpoena for use as evidence in court when a genuine case of serious misuse of the system has been identified.

Sensitivity of health information
The provisions in the MA Act and the HI Act reflect the principle held by the medical profession and the community that health information is extremely private and must be handled sensitively and by people who are qualified to understand the content. In a case before the Federal Court in 2008, Justice Reeves noted that "… medical records in general, let alone those dealing with a person's sexual health or activities, are generally regarded as being among the most personal information about an individual"[5].

It has also been acknowledged by the Federal Privacy Commissioner that, as a form of health information, medical records are sensitive information that generally afford a higher level of protection than other forms of personal information[6].

The AMA asks the Senate Committee to challenge government to identify what material change has taken place within the community that warrants Medicare Australia staff being given such broad legislative power to access and view information containing clinical details relating to patients when this very parliament has previously rejected this power.

Information to verify MBS billing
Medicare Australia is downplaying the provision in the Bill to access medical records by stating that in many cases a compliance audit will involve a simple administrative check of administrative information, not health information.

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[5] *C Incorporated v Australian Crime Commission* [2008] FCA 1806 (28 November 2008)
[6] *S v Health Service Provider* [2008] PrivCmr A 19 (29 August 2008)

Given that the very nature of a payment of a Medicare benefit is for a professional medical service provided to a patient, as noted earlier, in almost every case the information to verify an item requirement was met will be held in the patient medical record, and not in other documents as Medicare Australia suggests. We have continually advised government of this since this measure was announced in the last budget.

For example, Medicare Australia suggest that a doctor's appointment book will verify the time the doctor spent with a patient. This is not the case. An appointment book contains only a notional record of a doctor's schedule for a particular day – it is not retrospectively amended to record the names of the patients the doctor actually saw on that day or the time spent with each patient. Some doctors might record the length of time of the consultation in the patient record, and may be aided in this by their practice software. However, in most cases the only indicator of time spent with the patient will be the doctor's notes in the patient's record reflecting what happened during the consultation.

Similarly, if a doctor has ordered a test for a patient or referred the patient to another practitioner, those details will be held in the patient's record. Regardless of where that type of information is held, it is still clinical detail relating to a patient. The fact that an HIV test has been ordered for a patient is sensitive health information, regardless of where the information is held.

Another example is evidence that the patient meets the clinical requirements of an item, e.g. has diabetes. This information will only be held in the patient's medical record.

Consequently, the vast majority of Medicare Australia's simple administrative checks will be verified by information containing clinical details relating to a patient.

Patient confidentiality

Doctors make a unique commitment to society when they join the medical profession - to serve the needs of patients above all else through a longstanding tradition of medical professionalism. This embodies the profession's social and moral relationship with society where the profession uses its highly specialised knowledge and skills to serve the health needs of patients and the wider public. Doctors take their oath of patient confidentiality extremely seriously – it is an inherent part of medical professionalism. They do not hide behind patient confidentiality to avoid scrutiny. This legislation forces doctors to break their oath or face automatic financial penalties.

Ultimately the safety and quality of patient care is compromised. If patients' know their personal health information could be viewed by Medicare Australia officers this could well be a barrier to patients telling doctors everything they need to know in order to provide the best quality care. This will have profound consequences for individuals and for health across the country.

Further, we believe that the majority of the Australian people will not want their most personal health information that they share with their doctors being seen by Medicare Australia administrative officers carrying out administrative checks.

Government will need to explain to the Australian people why it wants/needs Medicare Australia to see their medical records as part of the MBS compliance process.

Patient Consent
There is no provision in the Bill, and Medicare Australia does not intend to notify, let alone obtain consent from, individuals when it seeks access to information from doctors to verify MBS item requirements have been met for services provided to a particular person[7].

Medicare Australia should be responsible for obtaining patient consent for medical records to be provided to Medicare Australia. This should be both broadly through public information campaigns that also explain why it is necessary to see medical records as well as contemporaneously from individual patients whose doctors are the subject of audits. Clearly, the information would need to be communicated carefully and appropriately and not in a way that puts doubt in the patient's mind about the clinical ability or professionalism of the doctor.

Increasing the number of audits

Justification
As previously stated, Medicare Australia seeks to justify the increased MBS compliance audits initiative on the basis that the MBS program has grown. The Government is yet to demonstrate that compliance with the MBS is worsening, or that increasing the number of audits will produce a greater number of "incorrect claims" from which the projected savings of $147.3 million can be recouped.

During Senate Estimates in February, a senior official from the Department of Health and Ageing admitted that the initiative is based on the belief that there is non-compliance and that "we do not necessarily know what the problems are until we have had an opportunity to do this increased auditing"[8]. Further, the projected savings are "best guesses".

This confirms that the underlying objective is to gain an additional power to go on a "fishing expedition" using patient health information to see what problems may exist.

Based on the total cost of administering the additional audits, the estimated cost per audit (or fishing expedition) is $9,600. Each audit would need to recover an average of $18,412 to achieve the projected savings. We know of one recent audit where the princely sum of $78.05 was recovered.

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[7] Explanatory memorandum, paragraph 1.60, page 10.
[8] Hansard, Senate Community Affairs Committee, Additional Estimates. 25 February 2009. Page CA102.

Given all of this we have strong reservations about the likelihood of achieving the savings stated by government through targeted audits.

We do know, however, that changes to billing occur when public statements are made about wrongdoing. In releasing the *2006-07 Report to the Professions* the Director of the PSR warned that GPs billing for longer standard consultations for multiple ailments could come under increased scrutiny[9]. In the period May 2008 to February 2009, billing of item 36 has steadily declined, with a saving of $84 million compared to Medicare benefits paid for the period May 2007 to February 2008.

Impact on patient rebates
The AMA is very concerned that the "incorrect billing" element of the Increased MBS Compliance Audits initiative will have unintended consequences, as has been illustrated by the decline in item 36 claims described above. Doctors, who are not confident in their interpretation of item descriptors and therefore nervous of being:

- the subject of a Medicare Australia audit;
- required to hand over their patients' medical records; and
- fined, in addition to the repayment of benefits, for items deemed to be incorrect

may respond by changing their billing practices in a variety of ways.

First, some doctors may be less inclined to include items on their accounts where there is doubt about their interpretation. The consequence of this will be higher out-of-pocket costs for patients through reduced rebates.

Second, other doctors may decide to provide written descriptions of their service, instead of providing item numbers, on their accounts. This would require additional administrative resources in Medicare Australia and would delay the payment of benefits for patients.

And still other doctors may not include those item numbers on their accounts that they believe might be audited, even if these items are the most appropriate to reflect the actual service provided. For example, many doctors who actually prepare a care plan already avoid billing under care planning items because of the administrative requirements these items impose on their medical management of the patient.

The complexity of the MBS
The proliferation of items, the complexity of their descriptors, and the morass of claiming rules have made the task of interpreting when Medicare benefits are, and are not, payable for a service more difficult for the medical profession and for patients. A decision by Medicare Australia that an item is incorrect, particularly when the item descriptor is equivocal, is at best subjective.

The Increased MBS Compliance Audits initiative will never ensure the integrity of the MBS. Much more effort needs to be put into simplifying MBS item descriptors and rules to make the MBS easier to comply with and to ensure the MBS reflects, and

[9] Medical Observer 23 May 2008.

does not dictate, medical practice. This would be more cost effective for government than undertaking expensive administrative compliance audits.

Impact on medical practices
There is already an impost on busy medical practices to comply with Medicare Australia audits. Under these new arrangements simple administrative checks will require patient files to be retrieved and reviewed, responses to notices to produce documents will need records and files to be retrieved and reviewed, and documents copied and posted to Medicare Australia. There will be lengthy discussions with Medicare Australia staff about what is actually required and whether documents provided have satisfied items requirements.

Red tape restricts patient access to care with some estimates suggesting that general practitioners, for example, already spend up to nine hours per week complying with red tape obligations. Medicare Australia audits will add to these red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to a GP.

In the case of the audit that recovered $78.05, the practitioner estimated over 10 hours was spent in complying the audit. There is a natural saving to Medicare if a doctor is diverted from providing care to patients, which will be of a higher order than the amount the audit will recover if Medicare Australia conducts fishing expeditions.

As we have already stated, the AMA is not opposed to reasonable compliance activity. However, we are unconvinced that the audits will be appropriately targeted while Medicare Australia undertake their fishing expeditions to find out if there is the level of non-compliance they believe there is.

Financial penalties

Procedural fairness
We have concerns with the lack of procedural fairness in the Bill including how a decision will be made that information provided by a doctor to Medicare Australia does not substantiate that item requirements were met, the consequences of which are that benefits are repayable and financial penalties apply.

Subitem 4(1C) in Schedule 1 of the Bill provides for an amount not properly substantiated by information contained in a document will become a debt due to the Commonwealth. There is no provision that identifies who will make this decision and against what criteria. We assume administrative officers of Medicare Australia will make these decisions, fulfilling an esoteric concept of satisfaction. This will inevitably lead to a variable benchmark, and inconsistency in decisions about incorrect claims and application of financial penalties.

There do not appear to be any provisions in the Bill for a doctor to argue mitigating circumstances before the decision is made, or to seek administrative review of the decision after it is made. As we understand it, the only avenue of recourse the doctor will have is through the Federal Court under the *Administrative Decisions (Judicial Review) Act 1977*. This is a time consuming and expensive process for a medical

practitioner to undergo in order to challenge an administrative officer's decision on what we believe in many cases will be a clinical matter on which they have no expertise.

While elements of procedural fairness are usually commonplace in Government's administrative decision-making processes, there is no evidence of this in the case of this legislation, or the administration of the compliance audits.

Financial penalties

The Bill would introduce punitive financial penalties based on a decision by a Medicare Australia staff member that an MBS item was billed incorrectly. Financial penalties will also automatically apply when:

- a doctor fails to respond to a notice to produce evidence, even if the doctor does not receive the notice,
- a doctor admits to incorrectly billing an MBS item, even if a notice to produce evidence has not been issued, or
- a doctor admits to incorrectly billing an MBS item during the course of an audit.

This creates a perverse incentive to encourage doctors to admit to incorrectly billing items with a value less than $2,500 and repay the benefit in order to:

1. avoid providing patient records;
2. bring an audit to a close; and
3. avoid paying a financial penalty.

We note that there is no obligation on Medicare Australia to verify that "admissions of guilt" actually relate to genuine incorrect claims. No doubt, the total amount of recoveries and penalties will laud the success of the Increased MBS Compliance Audit Initiative. It won't be clear how much of the recoveries were paid out of fear, rather than as a result of genuine detection of deliberate incorrect billing.

Amount of penalty

The AMA is not convinced that there is equity in applying a financial penalty where the amount of the penalty is based on the amount of the Medicare benefit for the service that is not properly substantiated.

Under these provisions, a cardio-thoracic surgeon who is audited for billing coronary artery bypass operations under MBS item 38503 for performing operations on two patients (a combined rebate of $3310.20) will incur a financial penalty. However, a general practitioner who develops GP management plans for 15 patients under MBS item 721 (a combined rebate of $1959.75) will not incur a financial penalty.

Medicare Australia appears to have taken the approach that penalties for incorrect billing should be based on the amount of the debt recoverable to the Commonwealth. As illustrated above, the variety of medical practice and the pricing structure of the MBS mean that, for the medical profession, the proposed penalty regime will be inequitable across medical professional groups.

Further, a penalty based on the total amount of incorrect claims could encourage Medicare Australia to audit doctors for large numbers of services, particularly for doctors practising in an area of medicine where services represent low value, high volume items.

If the “offence” is that an item has been billed incorrectly, then a penalty for each “offence” should apply.

Other concerns
Medicare Australia has indicated it will not specify the information that it considers will substantiate that MBS item requirements have been met. The AMA firmly believes it is possible for Medicare Australia to do this using the information it has already obtained through its compliance activities.

Such an approach would be consistent with compliance approaches of other government agencies, such as the Australian Taxation Office, which undertakes to make compliance as easy as possible for those who want to comply.

Given our concerns outlined above about the lack of procedural fairness in the audit process, we cannot accept a penalty regime that is based on the “wait and see” approach Medicare Australia is taking.

Conclusion

In principle, the AMA has no objection to increasing the number of audits per se and supports appropriate audit activity to ensure the integrity of the Medicare arrangements. However, the AMA has grave concerns that this policy has been ill conceived.

There is no evidence that there is an increase in non-compliance by the medical profession or evidence to justify the additional costs of the audits. The projected savings of $147.2 million are a “best guess”. Medicare Australia is unable to articulate the problems they expect to find. This suggests to the AMA that the audit process is geared towards recovery as the primary outcome and is, by its very nature, effectively seeking new powers to enable Medicare Australia to undertake a fishing expedition into the private clinical details of patients around Australia.

To draw on a medical analogy, the measures in this Bill are akin to vaccinating 100% of the population against a disease when the disease is prevalent in only a small number of the population, the vaccination is not a proven treatment and there are significant side effects. The AMA believes the side effects of the Bill will be:

- significant time wasted by doctors complying with audits that are poorly targeted;
- reduced confidence and trust between doctors and their patients that could compromise future patient care for individual patients; and

- high cost for taxpayers, because of the additional funding needed in Medicare Australia to undertake this activity, with no guaranteed return.

The AMA considers that a number of measures should be implemented instead of giving Medicare Australia such wide reaching unilateral powers to access patient records and to determine incorrect claims and apply financial penalties.

1. As part of formulating its compliance strategy, Medicare Australia should identify the high-risk services it has evidence require auditing.

2. Medicare Australia then should work with the profession to agree on what would constitute reasonable record keeping and information arrangements for these services that won't compromise patient care or introduce unnecessary additional red tape.

3. Once this has been agreed, Medicare Australia should work with the profession to undertake a major education campaign to advise the profession about how doctors can assist Medicare's audit activity around these specific services.

4. Guidelines should be developed for the decision making process, and the criteria for determining incorrect claims should be clearly documented and made publicly available.

5. The increased audits and other steps set out above should be evaluated after 12 months and a report provided to Parliament on the number of audits undertaken, the cost of each audit, the services that were the subject of each audit, the amounts recovered for each audit and an assessment undertaken with the medical profession of the administrative and patient impact of the revised audit processes undertaken under these arrangements as set out above.

April 2009

Attachment A

The Professional Services Review Scheme

The PSR Scheme

The object of the PSR Scheme is to protect the integrity of the Medicare benefits and pharmaceutical benefits programs by:

- protecting patients and the community in general from the risks associated with inappropriate practice
- protecting the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

The PSR Scheme was developed to provide an effective peer review mechanism to deal quickly and fairly with concerns about possible inappropriate practice. A practitioner engages in inappropriate practice if his or her conduct, in connection with rendering or initiating services, is such that the conduct would be unacceptable to the general body of the group (that is, medical practitioner, dentist, optometrist, chiropractor, physiotherapist, osteopath or podiatrist) in which the practitioner was practising.

A person who is an officer of a body corporate engages in inappropriate practice if the person causes or permits an employee to engage in inappropriate practice.

Key players in the PSR Scheme are:

- The Director of PSR, who is a medical practitioner appointed by the Minister for Health and Ageing with the agreement of the Australian Medical Association (AMA). Dr Anthony Webber was appointed Director of PSR on 14 February 2005 for a three year period. Dr Webber's appointment was extended for a further three-year term from 14 May 2008.
- The PSR Panel, comprising medical and other health care practitioners, who are appointed by the minister. At 30 June 2008, 165 members of the panel were available to serve on Committees. Of these, 21 were also appointed as Deputy Directors of PSR to serve as chairpersons of Committees.
- PSR Committees, comprising members of the PSR Panel, established by the Director on a case-by-case basis to consider the conduct of practitioners.
- The Determining Authority, comprising a medical practitioner as Chair, a layperson and a member of the relevant profession who are appointed by the minister. The Determining Authority's role is to decide on sanctions for practitioners found by Committees to have engaged in inappropriate practice and to consider whether to ratify agreements entered into by the Director and the person under review.
- Medicare Australia that makes requests to the Director of PSR to review the provision of services by practitioners.
- The Australian Government Department of Health and Ageing that has responsibility for legislation and policy relating to the PSR Scheme.

Medicare Australia requests to review
Medicare Australia asks the Director of PSR to review a practitioner's provision of services if it considers he or she may have provided those services inappropriately based on statistical data and other information. Medicare Australia has access to claims data and any information elicited by a medical adviser during a visit to a practitioner or from a practitioner's written submissions. The reasons Medicare Australia seeks review of the provision of services generally fall within distinct categories, including:

- prescribed pattern of services
- high volume of services
- high number of services per patient
- high prescribing of Pharmaceutical Benefits Scheme (PBS) drugs
- inadequate clinical input
- Medicare Benefits Schedule (MBS) item not satisfied
- services not medically necessary.

Cases of possible fraud PSR identifies in the course of its investigations are referred back to Medicare Australia for action.

Professional Services Review's process
The Director undertakes a review of the data received from Medicare Australia and may also direct the practitioner to produce a sample of medical records. Following examination of the medical records, a report to the practitioner and consideration of any submission received from the practitioner, the Director must:

- decide to take no further action
- enter into an agreement, or
- establish and make a referral to a peer review Committee.

No further action
Where the Director decides to take no further action, the Director writes to the person under review and Medicare Australia informing them of the outcome of the review.

Agreement
The Director may enter into a negotiated agreement with the person under review. Both parties sign a document containing an acknowledgement by the practitioner that he or she has engaged in inappropriate practice.

It may also contain an agreement for repayment of Medicare benefits and partial or full disqualification from Medicare. The Determining Authority must ratify the agreement for it to have effect. While the name of the practitioner remains confidential, the details of the inappropriate practice are published.

Committee
Where the Director considers the conduct of the person under review needs further investigation, a Committee is established. The Committee comprises members drawn from the panel appointed by the Minister for Health and Ageing. The Committee may conduct a hearing where the practitioner can provide both oral and written evidence in support of their case.

After considering all the evidence, the Committee produces a draft report containing findings on the practitioner's conduct. Where the Committee finds that the person under review has not practised inappropriately, the matter concludes. Where the findings are of inappropriate practice, the person under review is given time to make submissions on the draft report. After considering those further submissions a final report of any inappropriate practice is then forwarded to the person under review and the Determining Authority.

Determining Authority

The Determining Authority's role is to determine the sanctions to be applied in cases of inappropriate practice.

On receipt of a Committee's final report containing findings of inappropriate practice the Determining Authority must invite written submissions on any sanctions that may be applied, issue a draft determination, seek comments from the person under review on the draft determination and issue a final determination containing sanctions.

The sanctions may include reprimand and counselling by the Director, repayment of Medicare benefits and partial or full disqualification from Medicare for a maximum of three years. When a final determination comes into effect the Director can publish certain details, including the practitioner's name and address, profession or specialty, nature of the inappropriate practice and sanctions imposed.

Medicare Participation Review Committees

When a practitioner has attracted two effective final determinations the Director must provide a written notice to the Chairperson of the Medicare Participation Review Committees. Such committees have a discretionary range of options available, from taking no further action to counselling and reprimand and full or partial disqualification from participation in the Medicare benefits arrangements for up to five years.

Federal Court

At any stage in the process the person under review may seek judicial review in the Federal Court.